



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

August 18, 2011

CERTIFIED MAIL #: 7007 3020 0001 3745 7552

Judie Williams, Administrator
Ashley Manor Care Centers Inc - Elgin Way
3961 Elgin Way
Boise, ID 83713

Dear Ms. Williams:

Based on the Complaint Investigation and State Licensure Survey conducted by our staff at Ashley Manor Care Centers Inc - Elgin Way on **August 5, 2011**, we have determined that the facility retained a resident a wound that was not improving bi-weekly and the resident required skilled nursing care for treatment.

This core issue deficiency substantially limits the capacity of Ashley Manor Care Centers Inc - Elgin Way to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **September 19, 2011**. **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- ♦ What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- ♦ How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- ♦ What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- ♦ How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- ♦ What date will the corrective action(s) be completed by?

Return the **signed and dated** Plan of Correction to us by **August 31, 2011**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

Judie Williams, Administrator
August 18, 2011

You have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Care Program for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**August 31, 2011**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for Licensing & Certification to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **August 31, 2011**, your request will not be granted. Your IDR request must be made in accordance with the Informal Dispute Resolution Process. The IDR request form and the process for submitting a complete request can be found at www.assistedliving.dhw.idaho.gov under the heading of Forms and Information.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **September 4, 2011**.

Please bear in mind that any variance allowing the administrator to serve over other facilities is revoked as of the date of the exit conference. The facility must now employ a single, licensed administrator who is not serving as administrator over any other facilities. Failure to do so within thirty (30) days of the date of the exit conference will result in a core issue deficiency.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Ashley Manor Care Centers Inc - Elgin Way.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Program Supervisor
Residential Assisted Living Facility Program
Medicaid Licensing & Certification

JS/ka

Enclosure



IDAHO DEPARTMENT OF
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August 18, 2011

Judie Williams, Administrator
Ashley Manor Care Centers Inc - Elgin Way
3961 Elgin Way
Boise, ID 83713

Dear Ms. Williams:

An unannounced, on-site complaint investigation survey was conducted at Ashley Manor Care Centers Inc - Elgin Way from August 3, 2011, to August 5, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005002

Allegation #1: On 3/29/11, an identified resident laid all night in a urine soaked nightgown and soaked bedding.

Findings #1: On 8/3/11 through 8/4/11, observations, interviews and record reviews were conducted. During this time, the identified resident no longer resided at the facility. All residents were observed to be clean and well groomed. No urine odors were detected. Three caregivers interviewed stated they had not observed the identified resident wet when arriving on shift and checked the resident to ensure she was dry every two hours. One caregiver stated, the identified resident was occasionally observed with wet attends upon arrival for day shift, but was not urine soaked; the caregiver did not believe the resident had laid in urine all night. During the survey, three family members stated they had no concerns regarding the cares of the residents.

On 8/3/11 at 11:58 am, the administrator stated it could not be determined that the allegation had occurred upon investigation, but staff were in-serviced on ensuring the resident was checked for cleanliness every two hours when repositioning her.

On 8/3/11 at 2:00 PM, a hospice nurse involved with the resident's care, stated she had not observed the resident soiled or unkempt at any time. She had no

concerns with the care the resident received.

"Night Time Care Logs," for March 2011 and April 2011, documented the identified resident was checked for cleanliness and repositioned every two hours.

An in-service record, dated 4/22/11, documented six caregivers were instructed on changing residents in bed, proper toileting and following a temporary care plan for the identified resident. The identified resident's Negotiated Service Agreement was updated on 4/22/11 to include specific toileting instructions for the identified resident.

Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

Allegation #2: An identified resident fell out of bed multiple times and interventions were not put in place to prevent a recurrence.

Findings #2: On 8/3/11, the identified resident's record was reviewed. It contained incident reports documenting four falls, from January through March 2011. Each incident report documented the resident received necessary medical care and an investigation took place regarding factors contributing to the falls. The incident reports documented a bed alarm was initiated and a mattress was placed on the floor beside the resident's bed. Another incident report documented a plastic covering over the resident's mattress was removed to prevent the resident from sliding out of bed. The reports documented staff were trained on any increased care needs as a result of the falls, such as providing additional assistance with transferring. The identified resident's Negotiated Service Agreement was updated to include fall and injury prevention interventions.

On 8/3/11 at 10:35 AM, the administrator stated a mattress was purchased to place beside the resident's bed, which could be easily slid under the bed when visitors were present. The administrator showed surveyors the mattress. She further stated, staff were instructed to utilize bed and chair alarms and to check on the resident frequently.

Unsubstantiated.

Allegation #3: An identified resident lost a significant amount of weight and interventions were not put in place to prevent future weight loss.

Findings #3: On 8/3/11, the identified resident's record was reviewed. Medication assistance

records from January 2011 until April 2011, documented the resident received a high calorie nutritional supplement twice daily and an additional serving of a high protein item such as cottage cheese with each evening meal. The record contained hospice notes, which documented the identified resident's weight loss and lack of appetite was an expected outcome and staff were to assist with feeding when desired by the resident.

On 8/3/11 at 10:30 AM, a caregiver stated they provided the identified resident with Ensure and "super pudding," but she frequently refused to eat. "If she wanted food we would feed her, even if it was 2:00 AM."

Unsubstantiated.

Allegation #4: An identified resident's personal washcloths and blankets were missing.

Findings #4: Substantiated. However, the facility was not cited as they acted appropriately by implementing interventions to prevent the reoccurrence. An in-service record, dated 4/22/11, documented staff were instructed to wash residents' laundry separately. Further, upon interview of current residents and family members, it was determined there were no further complaints of missing personal belongings.

Allegation #5: An identified resident was not provided adequate assistance with grooming.

Findings #5: On 8/3/11 through 8/4/11, observations, interviews and record reviews were conducted. During this time, the identified resident no longer resided at the facility. All residents were observed to be clean and well groomed. Three caregivers interviewed stated they were instructed to assist the resident with grooming tasks and did not recall seeing her unkempt. During the survey, three family members stated they had no concerns regarding the cares of the residents.

On 8/3/11 at 2:00 PM, a hospice nurse involved with the resident's care, stated she had not observed the resident unkempt at any time. She had no concerns with the care the resident received.

An in-service record dated 4/22/11, documented six caregivers were instructed on providing assistance with brushing the resident's teeth and washing her face. The identified resident's Negotiated Service Agreement was updated on 4/22/11 to include specific grooming instructions.

Unsubstantiated. Although the allegation may have occurred, it could not be determined during

the complaint investigation.

Allegation #6: A medication aide was not on duty the night of 3/28/11

Findings #6: On 8/4/11, the as-worked schedule was reviewed for the month of March 2011. An employee record of the staff member who was scheduled the night of 3/28/11 was reviewed. It contained the appropriate medication certification (dated 12/8/10) and nursing delegation. Three other sampled employee records contained the necessary medication certification.

On 8/3/11, three caregivers stated they were unaware of a medication aid not being available to assist with medications. One caregiver stated she worked the night shift for two weeks prior to having been medication certified, but the administrator lived 5 minutes away and she was instructed to call her for any medication needs. She further stated, she did not have any problems reaching the administrator when assistance was needed.

On 8/4/11 at 2:00 PM, the administrator stated they implemented a "sleeper" staff member who was medication certified to sleep in the building, if the on-duty night shift staff member was not medication certified. The "sleeper" staff member would be awakened by the non-certified caregiver to assist with medications if needed.

Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

Allegation #7: Sufficient staff were not scheduled to meet the needs of the residents.

Findings #7: Between 8/3/11 and 8/4/11, observations of residents receiving cares were conducted on the day and evening shift. All residents were observed well groomed and received assistance with activities of daily living. Three family members stated they had no concerns regarding staffing and the cares the resident's received. Four caregivers stated they were able to assist residents with the required cares with the current staff available.

A letter, dated 4/22/11, documented a concern was brought to the administrator's attention regarding staffing. In response to the concern, two staff members were scheduled in the building, during all meal times, to assist with cares, feeding, and toileting.

Unsubstantiated.

Judie Williams, Administrator

August 18, 2011

Page 5 of 5

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

Karen Anderson, RN

Karen Anderson, RN

Health Facility Surveyor

Residential Assisted Living Facility Program

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program



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August 17, 2011

Judie Williams, Administrator
Ashley Manor Care Centers Inc - Elgin Way
3961 Elgin Way
Boise, ID 83713

Dear Ms. Williams:

An unannounced, on-site complaint investigation survey was conducted at Ashley Manor Care Centers Inc - Elgin Way from August 3, 2011, to August 5, 2011. During that time, interviews and record reviews were conducted with the following results:

Complaint # ID00005093

Allegation #1: The facility retained a resident with a wound that progressed to a Stage IV.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for retaining a resident whose wound was not healing bi-weekly. The facility was required to submit a plan of correction.

Allegation #2: The facility did not coordinate and identified resident's wound care with a hospice agency.

Findings #2: On 8/3/11 and 8/4/11, the identified residents record was reviewed. It contained care notes from the hospice agency documenting discussions that took place between the facility and the hospice agency regarding the identified resident's cares. Care notes from the administrator and facility nurse documented when the hospice agency was called or when the resident's cares were coordinated.

The identified resident's Negotiated Service Agreement documented the identified resident received hospice services and specified the services received.

On 8/3/11 at 9:00 AM, the administrator stated she would have a face to face meeting with the hospice nurse during each visit to discuss concerns and would review the notes the hospice agency left after each visit. Any concerns would be discussed with the facility RN.

On 8/3/11 at 9:15 AM, the facility RN stated she would observe the wound periodically when the hospice nurse was doing wound care and discuss any concerns. The administrator would also report any concerns to her identified during the visits from hospice, if she was not present.

Between 8/3/11 and 8/4/11, four caregivers stated they were instructed to call hospice if the resident's dressing needed changing and would notify the facility RN if the hospice RN was unable to change the dressing

Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

Allegation #3: Facility staff neglected to provide an identified resident with prescribed wound care.

Judie Williams, Administrator
August 17, 2011
Page 3 of 3

Findings #3: On 8/3/11 and 8/4/11, the identified resident's record was reviewed. It contained care notes documenting that the resident was repositioned every two hours, had barrier cream applied after toileting and an air mattress was utilized. The resident's record also documented a protein supplement was utilized to promote healing. During this time, four caregivers stated they repositioned the resident at least every two hours and kept her off the pressure sore. The identified resident's family stated the facility provided the necessary care to the resident including keeping her clean and dry and repositioning her.

Unsubstantiated.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Karen Anderson, RN

Karen Anderson, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2011
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NAME OF PROVIDER OR SUPPLIER ASHLEY MANOR CARE CENTERS INC - ELGIN	STREET ADDRESS, CITY, STATE, ZIP CODE 3881 ELGIN WAY BOISE, ID 83713
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>Initial Comments</p> <p>The following deficiency was cited during the licensure and complaint survey conducted on 7/7/11 through 7/8/11 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Karen Anderson, RN Team Leader Health Facility Surveyor</p> <p>Rachel Corey, RN Health Facility Surveyor.</p> <p>Definitions: Admin = administrator App = approximate ASAP = As soon as possible cm = centimeter HH = home health MD = medical doctor Necrotic = dead tissue R = right Res = resident RN = registered nurse slough = A layer of dead tissue that has separated from surrounding living tissue</p>	R 000	<p>16.03.22.520</p> <p>1) This resident discharged on 5/31/11 to a skilled nursing facility.</p> <p>2) other residents with wounds will be identified thru weekly skin checks by the administrator and staff at the building. These skin checks will then be sent to the RN for review and follow up. Specific wound documentation will be monitored by both the RN and the Administrator to watch for progression.</p> <p>3) In the event a wound is not healing bi-weekly, develops to a stage 3, or is a wound that cannot be cared for thru home health a resident will be given a notice to discharge immediately.</p> <p>4) this will be monitored by the weekly skin checks and the RN oversight. Currently there is no wounds in the building.</p> <p>5) 8/19/11</p>	
R 008	<p>16.03.22.520 Protect Residents from Inadequate Care.</p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, it was determined the facility retained 1 of 4 sampled residents (#4) for 26 days after it was determined</p>	R 008		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Judie Williams

TITLE
Administrator

(X6) DATE

9-19-11

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2011
NAME OF PROVIDER OR SUPPLIER ASHLEY MANOR CARE CENTERS INC - ELGIN		STREET ADDRESS, CITY, STATE, ZIP CODE 3981 ELGIN WAY BOISE, ID 83713		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 1 the resident's wounds were not improving bi-weekly and the resident required skilled nursing for treatment. The findings include: A. IDAPA rule 16.03.22.152.05.a states "A resident will be admitted or retained only when the facility has the capability, capacity, and services to provide appropriate care, or the resident does not require a type of service for which the facility is not licensed to provide or which the facility does not provide or arrange for, or if the facility does not have the personnel, appropriate in numbers and with appropriate knowledge and skill to provide such services;" IDAPA rule 16.03.22.152.05.b states "No resident will be admitted or retained who requires ongoing skilled nursing care not within the legally licensed authority of the facility. Such residents include: x. A resident with any type of pressure ulcer or open wound that is not improving bi-weekly." Resident #4 was admitted to the facility on 3/1/10 with diagnoses that included Alzheimer's dementia and hypertension. A nurse assessment, dated 3/13/11, documented the resident had a red area on her right buttock; the area was swollen and warm. The physician was notified of possible cellulitis. A nurse assessment, dated 3/22/11, documented the resident's wound was healing after having some drainage, but "continued to have a firm lump." On 3/29/11, the facility nurse documented a home health nurse was in to see the resident. Both the home health nurse and facility nurse	R 008		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER ASHLEY MANOR CARE CENTERS INC - ELGIN		STREET ADDRESS, CITY, STATE, ZIP CODE 3881 ELGIN WAY BOISE, ID 83713		
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R 008	<p>Continued From page 2</p> <p>observed a boil and it "continued to be red."</p> <p>The resident's record contained "Home Care Instructions," from a medical clinic, dated 3/30/11, that documented the resident had a boil that was lanced/excised to drain infection from the wound. The wound was packed with gauze to allow the cavity to heal from the inside outwards. Additionally, the resident was prescribed an antibiotic for treatment of the infection.</p> <p>On 3/31/11, the facility nurse documented, "Resident had boil excised on buttock, dressing in place with packing per MD order. HH in to provide care."</p> <p>On 4/12/11, the facility nurse documented, "Boil area not as deep but areas with shearing with resident scooting on pad. Surrounding area inflamed, Res to see MD. Late entry, hospital MD referred Res to hospice per family choice."</p> <p>A Hospice note, dated 4/18/11, documented "R buttock has changed significantly over the last few days." The note further documented, the wound increased in size and had brown drainage with a foul odor.</p> <p>On 5/4/11, the facility nurse documented, "Observed wound with hospice nurse. Area is larger with redness. Slough noted center app. 2 cm - 0.25 tunnel area at top of slough - Admin present will issue - 30 day notice...will discuss with spouse and assist with placement ASAP." The facility nurse did not document an assessment of the wound after the 30 day notice was issued.</p> <p>The resident's record contained a thirty day discharge notice, dated 5/5/11. The discharge</p>	R 008		

Bureau of Facility Standards

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R 008	<p>Continued From page 3</p> <p>notice documented the resident's medical condition had deteriorated and required a higher level of care due to a "wound not healing bi-weekly, started as a lanced boil."</p> <p>Hospice RN notes documented the following:</p> <p>*On 5/6/11, the wound was 3 cm x 4 cm with increased redness and a tan wound bed.</p> <p>*On 5/12/11, the wound was a Stage III, measuring 4 cm x 5 cm and the wound bed was black.</p> <p>*On 5/15/11, "Has what appears to be new areas where skin is no longer intact."</p> <p>*On 5/16/11, the wound appeared necrotic and measured 4 cm x 5 cm. Odor and tunnelling were present.</p> <p>*On 5/19/11, the wound measured 5 cm x 5 cm with increased redness and necrotic tissue.</p> <p>*On 5/28/11, the wound was a stage IV, and necrotic area measured 4 cm x 5 cm.</p> <p>Resident #4 was discharged on 5/31/11 to a skilled nursing facility. Admission paperwork from the skilled nursing facility, documented the wound was a stage IV on 5/31/11 and measured 9 x 7 cm with a depth of 10 cm.</p> <p>On 8/3/11 at 9:00 AM, the administrator stated "A caregiver observed a lump on the resident's right buttock." She stated, "I called the facility nurse to have her come assess the lump. The nurse recommended the resident be seen by a doctor, and the lump was diagnosed as a boil." She further stated, "A hospice nurse provided wound</p>	R 008		

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R 008	Continued From page 4 care daily. As soon as we realized the wound was not improving we issued a thirty day discharge notice." On 8/3/11 at 9:15 AM, the facility RN stated, Resident #4's wound started as a boil on her right buttock. The resident was sent to the hospital twice, to have the boil lanced. Both times the resident was treated with antibiotics for infection. The resident's physician ordered hospice services and a hospice nurse came to the facility to care for the wound. She followed the wound closely and when it was evident the wound was not healing, a thirty day discharge notice was issued. On 8/3/11 at 3:32 PM, an RN wound nurse from the facility the resident had been transferred to stated, "I assessed the resident upon admission, the wound was very massive and deep. I could see all the way to her spine." The RN stated, "the resident's wound should have had aggressive treatment before it turned into the horrific wound it is now." On 8/4/11 at 12:01 PM, the hospice RN stated, the hospice doctor did not order aggressive treatment for the wound, because he determined the wound would not improve. She stated, "My job was to make sure the dressing over the wound was kept dry and intact. I am a hospice nurse, not a wound nurse. I depend on the facility to let me know what is acceptable for assisted living facilities." The facility determined on 5/5/11, that Resident #4's wounds were not healing biweekly and required a higher level of care than what the facility could provide. After the 30 day notice was given, the facility RN did not assess the wound to	R 008		

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R 008	Continued From page 5 ensure the facility was meeting the resident's needs while placement was sought. The resident was not discharged until 5/31/11, and the wound continued to worsen. Twenty six days after the discharge notice was given, the wound progressed to a Stage IV and measured 10 cm in depth. The facility retained a resident who they did not have the capability and capacity to care for. This resulted in inadequate care.	R 008		



IDAHO DEPARTMENT OF HEALTH & WELFARE

Food Establishment Inspection Report

Food Protection Program, Division of Health
450 W. State Street, Boise, Idaho 83720-0036
208-334-5938

Establishment Name <u>Ashley Manor Elgin</u>		Operator <u>Dodie Williams</u>	
Address <u>2961 Elgin Way</u>			
County <u>ADA</u>	Estab # <u></u>	EHS/SURV <u></u>	Inspection time: <u>11 AM</u>
Inspection Type: <u>Standard</u>		Risk Category: <u>High</u>	Follow-Up Report: OR On-Site Follow-Up: Date: _____ Date: _____
Items marked are violations of Idaho's Food Code, IDAPA 16.02.19, and require correction as noted.			

# of Risk Factor Violations	<u>0</u>	# of Retail Practice Violations	<u>0</u>
# of Repeat Violations	<u>0</u>	# of Repeat Violations	<u>0</u>
Score	<u>0</u>	Score	<u>0</u>
A score greater than 3 Med or 5 High-risk = mandatory on-site reinspection		A score greater than 6 Med or 8 High-risk = mandatory on-site reinspection.	

RISK FACTORS AND INTERVENTIONS (Idaho Food Code applicable sections in parentheses)

The letter to the left of each item indicates that item's status at the inspection.

	Demonstration of Knowledge (2-102)	COS	R
<u>X</u> N	1. Certification by Accredited Program, or Approved Course, or correct responses, or compliance with Code	<input type="checkbox"/>	<input type="checkbox"/>
<u>X</u> N	2. Exclusion, restriction and reporting	<input type="checkbox"/>	<input type="checkbox"/>
<u>X</u> N	3. Eating, tasting, drinking, or tobacco use (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
<u>X</u> N	4. Discharge from eyes, nose and mouth (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
<u>X</u> N	5. Clean hands, properly washed (2-301)	<input type="checkbox"/>	<input type="checkbox"/>
<u>X</u> N	6. Bare hand contact with ready-to-eat foods/exemption (3-301)	<input type="checkbox"/>	<input type="checkbox"/>
<u>X</u> N	7. Handwashing facilities (5-203 & 6-301)	<input type="checkbox"/>	<input type="checkbox"/>
<u>X</u> N	8. Food obtained from approved source (3-101 & 3-201)	<input type="checkbox"/>	<input type="checkbox"/>
<u>X</u> N	9. Receiving temperature / condition (3-202)	<input type="checkbox"/>	<input type="checkbox"/>
<u>X</u> N N/A	10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203)	<input type="checkbox"/>	<input type="checkbox"/>
<u>X</u> N N/A	11. Food segregated, separated and protected (3-302)	<input type="checkbox"/>	<input type="checkbox"/>
<u>X</u> N N/A	12. Food contact surfaces clean and sanitized (4-5, 4-6, 4-7)	<input type="checkbox"/>	<input type="checkbox"/>
<u>X</u> N	13. Returned / reserve of food (3-306 & 3-801)	<input type="checkbox"/>	<input type="checkbox"/>
<u>X</u> N	14. Discarding / reconditioning unsafe food (3-701)	<input type="checkbox"/>	<input type="checkbox"/>

	Potentially Hazardous Food Time/Temperature	COS	R
<u>X</u> N N/O N/A	15. Proper cooking, time and temperature (3-401)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> N/A	16. Reheating for hot holding (3-403)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> N/A	17. Cooling (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>X</u> N N/O N/A	18. Hot holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N N/O N/A	19. Cold Holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>X</u> N N/O N/A	20. Date marking and disposition (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N N/O <u>N/A</u>	21. Time as a public health control (procedures/records) (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>X</u> N N/A	22. Consumer advisory for raw or undercooked food (3-603)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N N/O <u>N/A</u>	23. Pasteurized foods used, avoidance of prohibited foods (3-801)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/A</u>	24. Additives / approved, unapproved (3-207)	<input type="checkbox"/>	<input type="checkbox"/>
<u>X</u> N	25. Toxic substances properly identified, stored, used (7-101 through 7-301)	<input type="checkbox"/>	<input type="checkbox"/>
<u>X</u> N N/A	26. Compliance with variance and HACCP plan (8-201)	<input type="checkbox"/>	<input type="checkbox"/>

Y = yes, in compliance N = no, not in compliance
N/O = not observed N/A = not applicable
COS = Corrected on-site R = Repeat violation
 = COS or R

Item/Location	Temp	Item/Location	Temp	Item/Location	Temp	Item/Location	Temp
<u>Tapoco pudding</u>	<u>42°</u>	<u>Pork chops</u>	<u>169°</u>				
<u>Bricotta cheese</u>	<u>42°</u>	<u>Roasted Potatoes</u>	<u>167°</u>				

GOOD RETAIL PRACTICES (= not in compliance)

	COS	R		COS	R		COS	R
<input type="checkbox"/> 27. Use of ice and pasteurized eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 34. Food contamination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 42. Food utensils/in-use	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 28. Water source and quantity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 35. Equipment for temp. control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 43. Thermometers/Test strips	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 29. Insects/rodents/animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 36. Personal cleanliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 44. Warewashing facility	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 30. Food and non-food contact surfaces constructed, cleanable, use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 37. Food labeled/condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 45. Wiping cloths	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 31. Plumbing installed, cross-connection; back flow prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 38. Plant food cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 46. Utensil & single-service storage	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 32. Sewage and waste water disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 39. Thawing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 47. Physical facilities	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 33. Sinks contaminated from cleaning maintenance tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 40. Toilet facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 48. Specialized processing methods	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> 41. Garbage and refuse disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 49. Other	<input type="checkbox"/>	<input type="checkbox"/>

OBSERVATIONS AND CORRECTIVE ACTIONS (CONTINUED ON NEXT PAGE)

Person in Charge (Signature) <u>Judie Williams</u>	(Print) <u>JUDIE WILLIAMS</u>	Title <u>ADMINISTRATOR</u>	Date <u>8-5-11</u>
Inspector (Signature) <u>Rachel S</u>	(Print) <u>Rachel Cory</u>	Date <u>8-5-11</u>	Follow-up: (Circle One) <u>No</u>